CITY OF GULFPORT
EMPLOYEE BENEFIT PLAN
OVERVIEW
EFFECTIVE 1/1/08

PREMIUMS				
MEDICAL	EMPLOYEE /ONLY $16.50	EMPLOYEE /CHILDREN $94.50	EMPLOYEE / SPOUSE $160.50	EMPLOYEE / FAMILY $276.75
DENTAL ONLY $1,500	EMPLOYEE ONLY $10.00	EMPLOYEE /CHILDREN $29.75	EMPLOYEE / SPOUSE $35.25	EMPLOYEE / FAMILY $52.75
DENTAL ONLY $2,000	EMPLOYEE ONLY $15.00	EMPLOYEE/CHILDREN $34.75	EMPLOYEE/SPOUSE $41.25	EMPLOYEE/FAMILY $55.75
VISION ONLY	EMPLOYEE ONLY $3.25	EMPLOYEE/CHILDREN $5.27	EMPLOYEE/SPOUSE $5.24	EMPLOYEE/FAMILY $9.30
MEDICAL & DENTAL $1,500	EMPLOYEE ONLY $21.50	EMPLOYEE/CHILDREN $106.00	EMPLOYEE/SPOUSE $174.00	EMPLOYEE/FAMILY $297.50
MEDICAL & DENTAL $2,000	EMPLOYEE ONLY $26.50	EMPLOYEE/CHILDREN $111.00	EMPLOYEE/SPOUSE $179.00	EMPLOYEE/FAMILY $302.50
MEDICAL & $1,500 DENTAL & VISION	EMPLOYEE ONLY $24.75	EMPLOYEE/CHILDREN $111.27	EMPLOYEE/SPOUSE $179.24	EMPLOYEE/FAMILY $306.80
MEDICAL & $2,000 DENTAL & VISION	EMPLOYEE ONLY $29.75	EMPLOYEE/CHILDREN $116.27	EMPLOYEE/SPOUSE $184.24	EMPLOYEE/FAMILY $311.80

MEDICAL COVERAGE		
Services	**Network Providers**	**Non-network Providers**
Maximum Lifetime Benefit	$ 1,000,000	$ 1,000,000
Co-Insurance	**80/20**	**50/50**
Out-of-pocket Maximum		
▪ **Per Covered Person**	$ 1,500	$ 10,000
▪ **Per Family Unit**	3 individuals	3 individuals
Deductible		
▪ **Per Covered Person**	$ 500	$1,500
▪ **Per Family Unit**	3 individuals	3 individuals
Inpatient Facility Services		
▪ **Per Hospital Confinement**	$ 100 additional deductible	$ 750 additional deductible
▪ **Room and Board**	80% after deductibles	50% after deductibles
▪ **Intensive Care Unit**	80% after deductibles	50% after deductibles

MEDICAL COVERAGE CONTINUED		
Outpatient Facility Services		
▪ **Ambulatory/OP Surgery**	80% after deductible	50% after deductible
▪ **MRI/CT Scan, Ultrasound**	80% after deductible	50% after deductible
▪ **Diagnostic: Lab, X-ray, Mammogram**	80% after deductible	50% after deductible
Emergency Services		
▪ **Emergency Room Facility**	$ 75 additional deductible	$ 75 additional deductible
▪ **Emergency Room Physician**	80% after deductibles	50% after deductibles
▪ **Urgent Care Centers**	$ 25 Co-pay	50% after deductible
▪ **Ambulance Air/Land**	80% after deductible to nearest facility only	50% after deductible to nearest facility only
Other Outpatient Medical Services		
▪ **Durable Medical Equipment Rental/Purchase**	80% after deductible	50% after deductible
▪ **Prosthetic Medical Appliances**	80% after deductible	50% after deductible
▪ **Rehab Services Physical and Occupational, etc.**	80% after deductible	50% after deductible
Medical Services	**Network Providers**	**Non-network Providers**
Specialized Treatment		
▪ **Skilled Nursing Facility**	80% after deductible semi private room rate	50% after deductible semi private room rate
* **Registered Dietician**	80% after deductible (one time only with doctor referral and not for obesity treatment)	50% after deductible (one time only with doctor referral and not for obesity treatment)
▪ **Birthing Center**	80% after deductible	50% after deductible
▪ **Hospice Care**	80% after deductible $ 10,000 Lifetime Max	50% after deductible $ 10,000 Lifetime Max
▪ **Rehabilitation Facility Acute Care Only**	80% after deductible	50% after deductible
▪ **Home Health Care**	80% after deductible 100 visits Max	50% after deductible 100 visits Max
▪ **Private Duty Nursing *(Outpatient Only)***	80% after deductible $ 5,000 Year Max	50% after deductible $ 5,000 Year Max
▪ **Cardiac Rehabilitation initiated within 12 weeks after other treatment**	80% after deductible	50% after deductible
Mental/Nervous and Substance Abuse Treatment		
▪ **Inpatient (10 days CY Max / 30 days Lifetime Max)**	80% after deductible	50% after deductible
▪ **Outpatient (50 visits per CY)**	80% after deductible	50% after deductible
▪ **Not Covered (May be covered under EAP Plan)** **Marital Counseling, Family Counseling Sex Counseling, Hypnosis**		

MEDICAL COVERAGE CONTINUED		
Preventive Care		
▪ **Routine Well Adult/ Well Child Care**	100% up to $800.00 with no Co-pay	N/A
Note: $800 includes routine, preventive, screening, OB/GYN and physician exam and immunizations		
▪ **Hearing Test - (Only 1 visit per year)**	100% up to $800.00 with no co-pay	0% after deductible
▪ **Immunizations (under age 19)**		N/A
Services	**Network Providers**	**Non-network Providers**
Pre-Natal Visits and Physician Services for Delivery	80% after deductible	50% after deductible
▪ ***Physicians Service for OB**	80% after deductible	50% after deductible
PRESCRIPTION DRUG BENEFITS		
Please refer to SPD for Exclusions)		
Retail		
▪ **Generic Brands**		$10.00
▪ **Brands with generics**		$20.00
▪ **Brands without generics**		$35.00
Mail-Order/Retail (90-day) Maintenance Drugs Only Expected to be on for 1 year or more.		
▪ **Generic Brands**		$10.00
▪ **Brands with generics**		$20.00
▪ **Brands without generics**		$35.00
DENTAL BENEFITS		
Dental Benefits	**Option I**	**OPTION II**
Preventive Services:100%	Deductible- $50 Individual /$150 family	Deductible- $50 Individual /$150 family
▪ **Basic Services: 80%**	Plan Year Max - $1,500	Plan Year Max- $2,000
▪ **Major Services: 50%**	Ortho Lifetime Max $1,500	Ortho Lifetime max $2,000
▪ **Ortho Lifetime Max- $1,500 or $2,000 Up to age 19**		Benefits limited to dependent children up to age 19, to age 24 if full-time student
OPTIONS: $1,500 OR $2,000		

VISION-VSP		
Exam for glasses-	**NETWORK**	**OUT OF NETWORK**
Optometry Exam	$25 co-pay 1 x 12 month	Up to $35 reimbursement
Ophthalmology exam		Up to $35 reimbursement
Glasses		
Complete pair eyeglasses	$25 co-pay 1 X 24 month	Up to $45 reimbursement
Frame only	$25 co-pay 1 X 12 month	
	OR	
Contact Lenses	Up to $120.00 per year	Up to $105.00 per year
Life Insurance Coverage-$50,000 FREE **Accidental Death & Dismemberment Insurance Coverage- $50,000 FREE**		
Employee Assistance Program-FREE **A free confidential counseling service available to employees and their families; provided by New Directions.**		
WELLNESS CLINIC –FREE **Acute care, primary care and specialty services**		
***Please refer to Summary Plan Description, PERS Member Book or Employee Handbook**		